

Triage of Suspected/Proven COVID Patients in the Emergency Department/ Wards

Approval and Authorisation

Approval Group	Job Title, Chair of Committee	Date
GOLD COMMAND (pending)	COVID-19 COMMITTEE Enter personnel present	23.3.20

Change History

Version	Date	Authors, job title	Reason
2.0	29.9.20	Andrew Walden Acute Medicine Consultant David Clarke ED Consultant Zac Etheridge Acute Medicine Lead Joseph Nunan Ultrasound Fellow in Acute Medicine Georgie Brown Matron, Acute Medicine	

Consultation undertaken on this policy

This policy has been the subject of consultation with key members of Emergency Department, Acute Medical Department, Intensive Care Department and The Ambulatory team.

Implementation

This approved policy will be placed on the intranet and will be cascaded through directors to line managers and staff.

Background

During the first peak of the pandemic caused by SARS-CoV-2, the acute medicine and emergency medicine departments developed a triage pathway for patients with COVID, whereby some patients with COVID could be sent home and remotely monitored. This COVID triage pathway is called TICC-19 and proved hugely successful to patients, staff and the hospital.

Three main advantages exist to the TICC-19 pathway:

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- 1) Allowing for lung ultrasound instead of chest x ray by clinicians competent in this skill;
 - 2) Standardising the 'stress test' to a 30 metre walk test;
 - 3) Sending patients home with a sats probe and monitoring them remotely.
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Many hospital admissions were avoided, and patients were sent home from wards sooner.

In response to the second wave of the pandemic, the Acute Medical Unit has responded by rolling out the TICC-19 project in collaboration with their ED and acute ward colleagues. A number of iterations occurred during the last peak, and have been put in to place in the interim period.

A key difference is the renaming of the COVID ambulatory clinic to the 'AMU virtual ward' to avoid confusion with the Ambulatory Emergency Care Unit.

The aim of this project is to reduce pressure on the system by distinguishing between patients who need to remain in hospital and those who can be reviewed safely at home. For those presenting to the emergency department or hot hub it will be necessary to triage patients effectively and in view of the delayed onset of hypoxia in some patients, to have a robust way of identifying those patients who are safe to go home, those who need to come in for a period of observation and those who may be able to be reviewed in an ambulatory setting.

The AMU virtual ward aims to offer patients the safety of the hospital in the comfort of their own homes.

It is important to realise that this pathway is a guideline only. We have not used the NEWS score within this algorithm as the predominant organ failure with COVID-19 is respiratory and hypoxic in nature so clinicians using this tool will need to take into consideration the overall condition of the patient and use their clinical judgement as to who and who should not be discharged to an ambulatory pathway.

Triage Flowchart for Covid-19 Positives/ Suspected

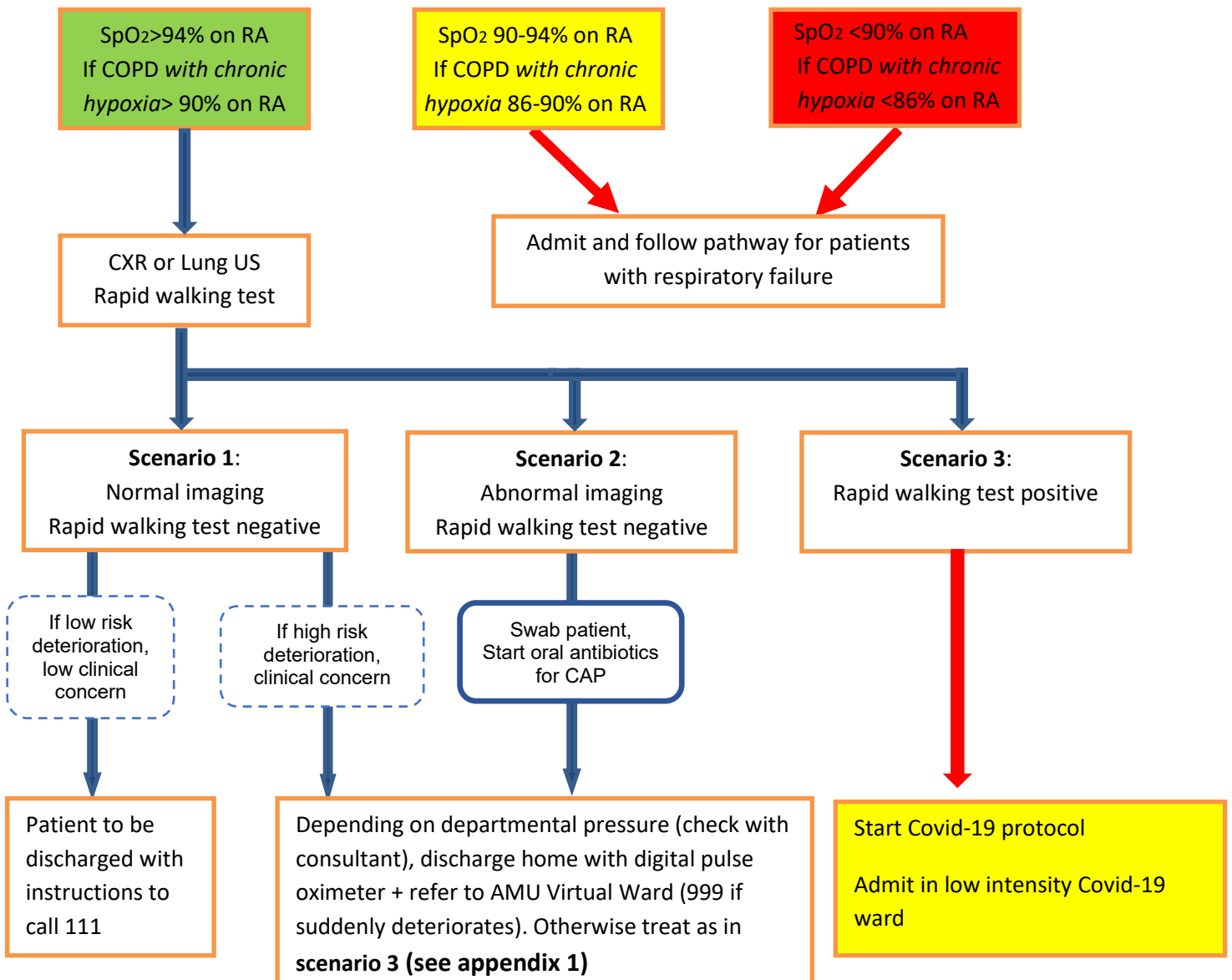
New, continuous cough?
 Shortness of breath?
 Fever >37.9C?
 Loss or change of smell/taste?
 Pneumonia suspected or already diagnosed (imaging positive)?
or other clinical suspicion of Covid-19

* FLOW CHART IS A GUIDELINE ONLY *

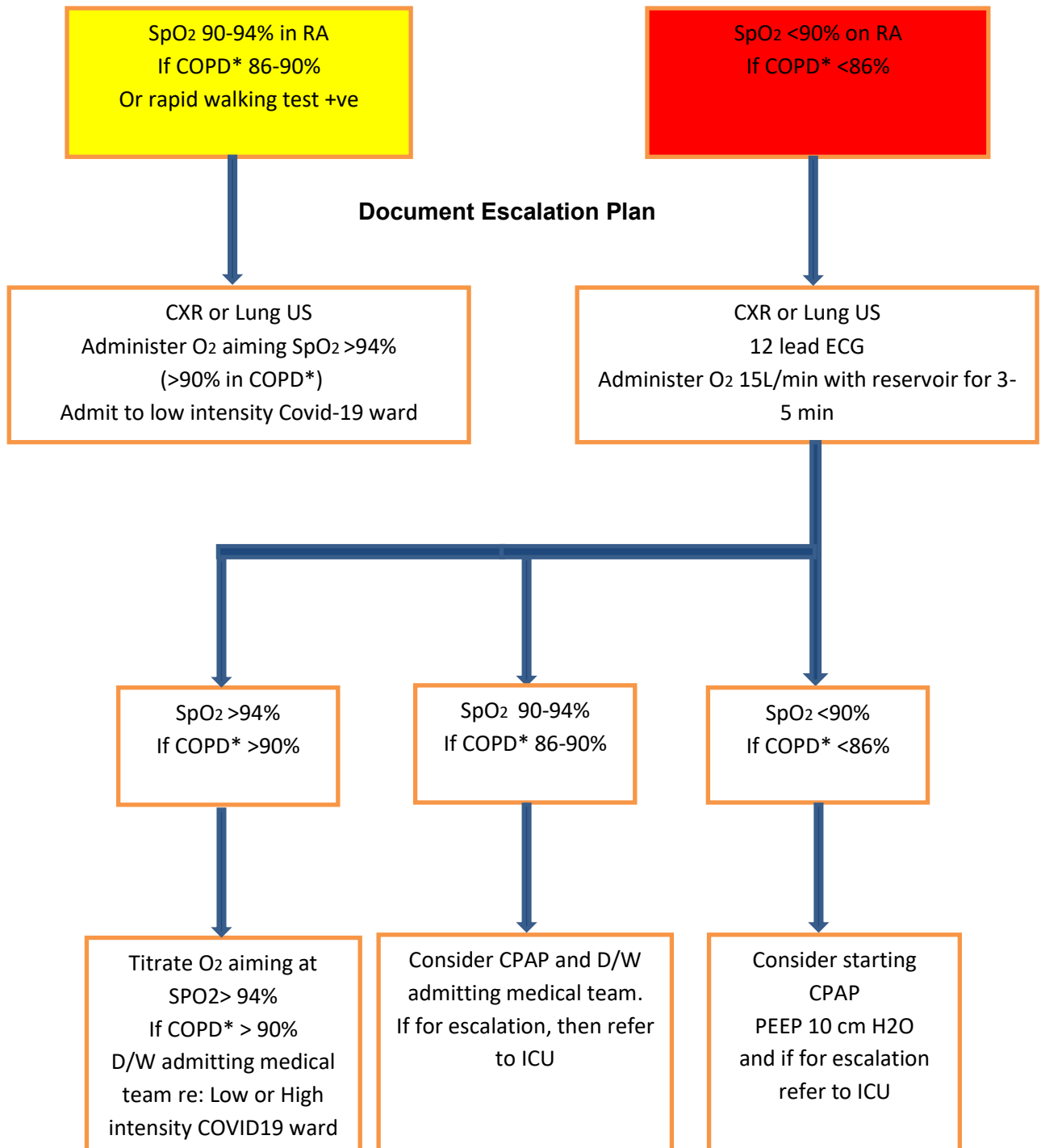


Aims:

1. Identify suspected Covid-19 patients who do not require hospital admission.
2. Start intensive therapy pathways for those with respiratory insufficiency.



Pathway for Covid-19 Positives/Suspected with Respiratory Failure



*See accompanying appendix 1 for notes on COPD

Appendix 1

1. Rapid walking test.

Take baseline oxygen saturations. Encourage the patient to walk at the highest possible speed for 30 meters on a linear path. Sit the patient down and re-measure oxygen saturations. The test is considered positive if the absolute oxygen saturation has fallen by more than 5%.

Stepping quickly up and down a 2 steps stool for 30 seconds could be an alternative in limited spaces (no supportive evidence).

2. A note on patients with COPD.

Many patients with COPD do not have sats of 88-92% but do in fact have normal sats, so do not assume that the patient with low sats who has COPD represents a patient with 'normal' sats for them. They may be severely unwell. If in doubt, do an ABG or admit.

3. Lung Ultrasound.

Lung ultrasound should only be used in place of a chest x ray by clinicians confident in their lung ultrasound ability. 12 point lung ultrasound. If A lines (horizontal lines) in all zones then lung ultrasound 'normal' If anything more than 2 B lines at the four base points the scan is abnormal. If multiple B lines at the base patient can be discharged. If consolidation or confluent B lines, admit. If anterior or posterior B lines more than 2 in two areas, admit.

4. Adaptation of pathway for inpatient use.

Patients assessed as inpatients on medical wards may be able to go through the same triage pathway to be discharged (ie walking test negative but imaging changes to go home with a sats probe and monitored through ambulatory).

Pathway for Suspected / Confirmed COVID patients in the AMU Virtual Ward

FLOW CHART IS A GUIDELINE ONLY

Skype / Phone patient

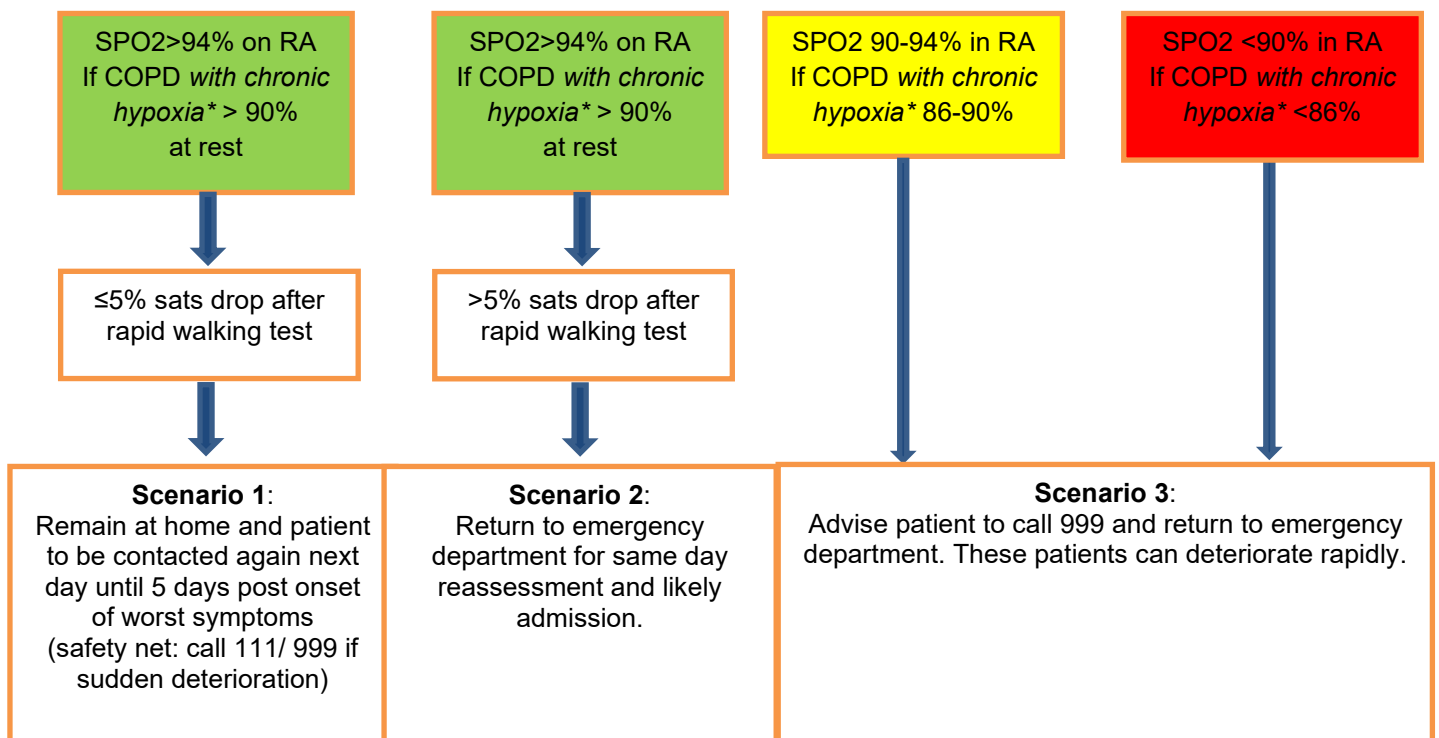


Ask for sats readings at rest and walking test sats readings



Aims:

1. Identify confirmed / suspected Covid-19 patients who can remain at home whilst monitored in the AMU Virtual Ward.
2. Identify confirmed / suspected Covid-19 patients who need to return to hospital.
3. Identify those patients who no longer need monitoring.



*See accompanying appendix 1 for notes on COPD

Appendix 2

1. Covid-19 ambulatory pathway.

About 20% of patients who are discharged from the emergency department on this pathway will require readmission. Mortality for patients who fail the walking test can be as high as 20%.

2. A note on patients with COPD.

Many patients with COPD do not have sats of 88-92% but do in fact have normal sats, so do not assume that the patient with low sats who has COPD represents a patient with 'normal' sats for them. They may be severely unwell. If in doubt, do an ABG or admit.

3. Rapid walking test.

Take baseline Sats. Then the patient should walk at the highest possible speed for 30 meters on a linear path. Measure Sats. The test is positive if the patient loses more than 5% sats.

Stepping quickly up and down a 2 steps stool for 30 seconds could be an alternative in limited spaces (no supportive evidence).

Appendix 3

- To refer a patient to the AMU Virtual Ward please call Ex 8104 Mon-Sun 9am to 5pm. Outside of these times please email the referral to Ticc19@royalberks.nhs.uk. Please ensure you have:
 - patients oxygen sats at rest and after the 30 metre walking test
 - a current contact number

After the patient has been referred, they will be phoned from the AMU Virtual Ward the next day.

- Ask the patient to call the Patient Information Line on 01183225201 if they do not hear from the AMU Virtual Ward team by 1pm the next day.
- Then give the patient information leaflet and pulse oximeter to the patient.

Appendix 4

Modifications as of October 2020

- Patients will not be accepted without a phone number, sats probe, patient leaflet, diagnosis, baseline sats, walking test sats.
- Patients sent home without sats probes and phone numbers etc will be handed back to the referring team.
- The COVID ambulatory clinic is now called the AMU Virtual Ward (to avoid confusion with ambulatory which is a different service).
- Patients can be referred with negative COVID swabs, or if you think the diagnosis is flu, but this needs to be documented.